Executive Summary

Strategies for Diffusing Health Information to Minority Populations

A Profile of a Community-Based Diffusion Model

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Public Health Service
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September 1987

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FOREWORD

This booklet profiles a community-based diffusion model (CDM) that can be used to disseminate multiple risk factor information to culturally diverse audiences. The CDM emphasizes nine critical processes for planning and implementing community-based diffusion strategies. While focusing on the importance of centering diffusion activities at the community level, the model also acknowledges appropriate roles for individuals and organizations outside the core community. The main purpose of the model is to promote effective collaboration among the individuals and organizations that can be involved in a diffusion effort. The model is not prescriptive; rather, it is a composite of effective community approaches that can be used as a guide in developing community-based minority programs.

The primary audience for the CDM includes community-based health care providers, educators, and administrators who are interested in and who provide community-based services to minorities, as well as local administrators who can provide valuable support. Another important segment of the audience includes health planners, program administrators, and health educators.

The model was developed by Anrow Sciences of Mandex, Inc., under contract to the National Heart, Lung, and Blood Institute. The project examined the diffusion strategies necessary for specific minority populations: American Indians, Asians/Pacific Islanders, blacks, and Hispanics. High blood pressure and high blood cholesterol were the health problems that were studied. A full report of the project is available from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161--"Development of Diffusion Strategies Among Culturally Diverse Populations," Order no. PB 85160497 HAS.

INTRODUCTION

The National Heart, Lung, and Blood Institute (NHLBI) strongly supports prevention as a cost-effective means of reducing morbidity and mortality from cardiovascular and pulmonary diseases. Because an individual's awareness of health risks is a major factor in disease prevention, NHLBI has emphasized health education and information efforts. However, minority populations are not always reached by mainstream health education activities. Thus, NHLBI developed the community-based diffusion model (CDM) to address the specific health communications needs of minority audiences.

The CDM focuses on high blood pressure and high blood cholesterol because of their prevalence in certain minority groups and because each risk factor could be addressed by a variety of interventions. In developing this model, our objectives were:

- To identify and assess relevant research on the diffusion of health information to culturally diverse populations,
- To identify and characterize the factors that promote or impede the diffusion of research findings to minority groups,
- To develop guidelines for using local resources and personnel to promote the diffusion process at state and community levels,
- To identify tools for conducting diffusion activities according to these guidelines,
- To specify evaluation methods for measuring rates of adoption appropriate to the different communication approaches used for different minority groups,
- To identify past and present community efforts that demonstrate effective diffusion activities, and
- To recommend diffusion activities and assign priorities among them.

The development of the model involved extensive literature reviews, intensive strategy development workshops, site visits to exemplary minority health programs, and consultation with minority health experts.

THE COMMUNITY-BASED DIFFUSION MODEL FOR CULTURALLY DIVERSE POPULATIONS

No matter what the audience, certain basic principles must be observed in planning diffusion programs. In fact, the success of any diffusion program depends, to a large extent, on how well planners observe the following principles.

Essential Planning Principles

- Know your client populations, be sensitive to the beliefs and needs of the constituent groups, and base your operating assumptions about the populations or constituent groups on local assessments.

  Avoid using broad racial characterizations because you risk stereotyping and thus alienating your target audience.

- Base your selection of a target population on validated research findings.

  Assess your target population before you begin diffusion efforts. Otherwise, you risk addressing a health problem that is irrelevant to the target population, reducing the credibility of change agents through careless targeting of health messages, and falsely discrediting diffusion materials through misdirection, compromising the efforts of other health educators.

- Base decisions concerning the diffusion of health information on validated biomedical research findings.

  Health information or innovations should be diffused only if scientific consensus exists with regard to their validity and value. Conflicting information from different diffusion programs can undermine the credibility of the change agents, while ineffective health recommendations will undermine the program itself.

The Importance of Community Involvement in Diffusion Strategies

Members of ethnic and cultural minorities often cluster in communities that provide some measure of social support or maintain extended social networks. People from the same ethnic group typically share beliefs, values, and social and educational experiences. This shared reality suggests that diffusion strategies developed for and with the community will be more effective than those planned and implemented solely by agencies at the national, state, or municipal level. Nevertheless, program personnel should not assume the homogeneity of any community when planning diffusion strategies. Each community must first be assessed to determine its particular characteristics and needs.

Factors Necessitating Local Involvement

- Unique sociodemographic features of specific culturally diverse communities.

  Do not assume that all communities within a specific minority group are the same. History, location, and a host of other factors produce striking differences between ethnically similar communities and even between members of the same community.

- Elusiveness of local communication networks.

  There is nothing reliably generic about communication patterns within minority groups, even within ethnically similar groups. Each community has its own opinion leaders and unique set of communication channels, which may not be easily identified or traced by an outsider.

- Community pride in local talent and know-how.

  Recent decades have seen a growing political awareness among the minority populations in this country, accompanied by considerable community pride and a powerful desire for complete self-determination. As a result, what minority communities want is the funding and technical assistance needed to develop their own, culturally relevant solutions.

- Community suspicion of outside change agents.

  An outside change agent should expect that his or her motives and competence will be questioned by community members. Change agents should be aware of potential suspicion and skepticism from community members and should devise strategies for handling such situations.

PROCESSES INVOLVED IN DIFFUSION EFFORTS

Exhibit 1 portrays the CDM schematically. The core community is envisioned as part of a larger community made up of outside agencies and organizations at the local, state, and national levels. Co-change agents, who are part of the core community, are opinion leaders who are actively involved in diffusion efforts. Members of the core community (i.e., community co-change agents) carry out the nine critical processes defined in the sequence of boxes, with support from other levels. Note that the boxes marked with an asterisk are those processes considered essential for diffusion efforts aimed at minority groups.

Most community diffusion efforts will involve these nine processes. The first is an organization-building activity, the next three are information-gathering tasks, and the remaining five are steps required to develop, implement, and operate appropriate diffusion projects. The steps are described below:

(1) **Establish a working group of co-change agents**--This primary process, placed at the center of Exhibit 1, is not a one-time task but an ongoing management and coordination effort for the entire diffusion program. Although the same one or two community members may provide overall program management, it is likely that the group of co-change agents and opinion leaders engaged in planning and implementing program strategies will expand, contract, and alter over time, in response to shifting needs.

(2) **Recognize the problem and seek help**--Becoming aware of a problem and making others aware of that problem is a process that can be initiated within the core community or can result from the community's contact with change agents from the larger community.

(3) **Assess the community**--Although knowledge of the community is crucial for the success of diffusion efforts, an assessment sufficient to produce this knowledge need not be extensive or time-consuming, particularly if it is undertaken with the help of knowledgeable community co-change agents.

(4) **Determine measurable goals**--This generic process is necessary for planning, monitoring, and evaluating all projects, including diffusion efforts.

(5) **Plan diffusion activities**--Although plans should be precise, persons who implement programs should be free to change their strategy or introduce a new approach if a change is indicated by ongoing program monitoring and evaluation.

(6) **Prepare communication tools**--The written and audiovisual materials used to convey health messages should always be carefully tailored to the target population. If suitable tools cannot be borrowed and adapted for community purposes, they must be developed for the particular population and problem being addressed.

(7) **Pretest**--Diffusion activities and materials should be tested on a small sample of the target population and revised, if necessary, before being adopted.

(8) **Implement and monitor the plan**--Monitoring should continue throughout implementation so that programs can be modified if necessary.

(9) **Assess the final results**--Assessments will generate documentation of program activities and outcomes that can be useful in developing future diffusion programs for the community or for other communities.

These nine processes are basic to any diffusion effort, but they may not always be necessary. For instance, assessments conducted for previous diffusion programs (or the collective knowledge of selected co-change agents) may eliminate the need for a full-fledged community assessment.

Networking With Outside Agencies

As Exhibit 1 illustrates, the core community fits within and is reinforced by the larger community. Federal, state and local government agencies, as well as private sector organizations that have health-related interests, can be approached for various types of assistance. Although it is difficult for these groups to be involved in the daily planning and implementation activities of community-based programs, there are specific ways that outside agencies can work with the core community on diffusion efforts. Outside agencies offer many resources that can support community efforts:

- **Funding**--Recent trends in health and social service programming have shifted funding responsibility from Federal to state and local levels. Private foundations and corporations are also possible sources of funding.

- **Research**--New solutions to problems are discovered through research, usually conducted or sponsored by Federal agencies or by national organizations like the American Heart Association. It is important to interpret research findings and translate relevant findings into practical information that can be appropriately disseminated.

- **Technical assistance**--This type of support includes help in developing printed or audiovisual materials, community organization, public relations, and "how-to" information that is not easily available to the community.

- **Clearinghouse function**--Large organizations can often provide bulk quantities of evaluated materials and can also take locally developed materials and make them available nationally.

- **Public relations**--Endorsement by a national organization respected in the community (e.g., National Urban League) can increase the visibility and credibility of diffusion efforts, creating broad-based networks of support for community co-change agents.

KEY DIFFUSION PROCESSES FOR MINORITY PROGRAMS

The processes of the CDM are applicable to diffusion efforts for any target population. However, four in particular are critical to planning minority programs: establishing working groups of co-change agents, assessing the community, planning diffusion activities, and preparing communication tools. These four processes are explored in greater detail below.

(1) Establish a Working Group of Community Co-Change Agents

This step is one of the most crucial prerequisites for successful diffusion in minority communities. Whether the impetus for diffusion programs comes from inside or outside the community, it is necessary that community

co-change agents be involved in all stages of program development, because they can lend credibility and visibility to the diffusion effort. Since they often have professional, social, and familial ties to the community, co-change agents also have access to information that is unavailable to outsiders. They are familiar with local language preferences, health beliefs, and health practices as well as community health care resources and how these are used. In addition, they can identify community opinion leaders, communication networks, and local experts who might be useful to the program.

The names of potential co-change agents can often be identified with the help of national organizations that have chapters operating at the local level. Usually, these agents are community opinion leaders and, as such, they may or may not have formal and obvious positions of power and influence. Opinion leadership is an informal status that is not necessarily tied to a specific occupation. Even ethnically similar groups will vary in their choice of opinion leaders. Exhibit 2 gives examples of community co-change agents.

One way to organize a working group of opinion leaders is to establish a community advisory panel whose members can contribute to planning and implementation as they are able. One or more of the leaders may accept responsibility for managing or coordinating the program, while others may provide more limited advice, assistance, and support. Once opinion leaders recognize a problem in the community and become active in seeking a solution, they are considered community co-change agents.

(2) Assess the Community and Its Needs

All effective diffusion programs require a thorough knowledge of the target community. However, assessment is particularly important in minority communities, since the potential for cultural diversity and the associated risks of irrelevant or stereotypic messages are much greater.

Carefully selected community co-change agents should know much of the information that would otherwise require extensive assessment. However, co-change agents should not assume that their knowledge of the community is complete; nor should their analysis be taken as absolute. Sometimes their positions of leadership distance them from the target audiences and it is desirable for community co-change agents to continually seek information from other community members. For example, they might set up well-defined discussion groups (e.g., focus groups) consisting of target audience members.

Certain community characteristics tend to influence the reception of health messages or innovations, and exhibit 3 lists community characteristics that may affect diffusion efforts. This list, or one similar, should be reviewed by community co-change agents, who should be able to indicate the importance of each characteristic for the diffusion effort being planned. In general, there are four major areas that should be analyzed before proceeding with a diffusion effort: community health problems and risks; use of the mainstream health care system; traditional health beliefs and practices; and educational level, literacy, and language preferences.

- **Community health problems and risks**--Diffusion efforts should be directed at health problems that clearly affect the target community and should be designed with an awareness of pertinent risk behaviors. Health problems may be easier to assess than health practices, but it is difficult to obtain information on either factor.

  For example, most public agencies will not have epidemiological data that are detailed enough to support community diffusion efforts. Thus, planners may need to gather data from individual health care professionals and health centers that primarily serve minority populations. These providers may be able to provide aggregate data or well-informed estimates of the incidence of specific health problems among different ethnic groups in the community.

  Centralized information sources on risk behaviors generally have not been available. For example, in the early 1980's, the Centers for Disease Control (CDC) began to assist 24 states and the District of Columbia in establishing surveillance systems for six high-risk behaviors--smoking, obesity, uncontrolled hypertension, heavy drinking, sedentary life style, and lack of seatbelt use. Thus, more data should be forthcoming on relevant risk behaviors, at least in some areas of the country.

  Another data-gathering resource is the community survey, which does not necessarily require a large number of randomly selected respondents. Discussions with small groups of selected informants is adequate, and these informants are best chosen from the group of potential community co-change agents.

  Since high blood pressure and high blood cholesterol are related to diet, diffusion messages that target such risk factors should be based on detailed knowledge of the target population's dietary practices and other pertinent behaviors, such as smoking and exercise. Erroneous assumptions about diet are easily made by uninformed change agents. For instance, despite popular belief, all blacks do not subsist on "soul food," nor do all Asians consume huge quantities of salt fish, monosodium glutamate, or soy sauce. Ironically, many blacks regularly enjoy Asian cookery, and many Asians prefer a diet of pizza, hamburgers, and french fries--typical "American" fare. Moreover, monosodium glutamate and other food additives are frequent ingredients in frozen and prepared foods used by the majority population.

- **Use of the mainstream health care system**--It is true that some members of ethnic groups may visit herbalists, curanderos, medicine men, or other traditional healers before turning to the mainstream health care system. But planners should never assume that the target population differs markedly from the majority population in its health care preferences. Instead, planners should seek to understand the role, pattern of use, and impact of the local, mainstream health care system. This information may be obtained by analyzing the caseloads of major health care providers--private physicians, neighborhood clinics, hospital emergency rooms, and other health care resources.

- **Traditional health beliefs and practices**--Planners should recognize existing traditional health beliefs and practices, acknowledge their potential benefits, and attempt to work with them rather than against or despite of them. Whenever possible, planners should try to disseminate new information about health care in a manner that is compatible with existing beliefs.

  For example, some Hispanics believe that health conditions are either "hot" or "cold" and that hot conditions should be treated with cold remedies and vice versa. Since pregnancy is considered a hot condition, pregnant women are likely to reject vitamins--a hot treatment. The effective approach is to recommend that vitamins be taken with cold fruit juice, a measure that would be perceived as preserving the body's essential hot/cold balance. Similarly, in treating some Asians/Pacific Islanders who consider certain herbs as specific for certain diseases, the knowledgeable and sensitive health care provider might recommend that medicine prescribed for high blood pressure be taken in conjunction with an herbal tea. This would satisfy the health care provider's own desire for a therapeutic effect without going against the patient's beliefs, which may, in fact, possess some undocumented benefit.

  In brief, for those members of the target population who continue to hold traditional health beliefs, it is more effective to fit new health information into the old frame of reference than to "educate" these beliefs away. Health care providers should be warned, however, that indiscriminate use of this practice can appear patronizing. A thorough examination of the patient's health beliefs should be undertaken before prescribing any treatment regimen.

  Furthermore, in communities where folk healers are respected and consulted, these healers should be enlisted in the diffusion effort. People may use traditional resources for some purposes and mainstream resources for others. Thus, since traditional healers may be more accessible and less threatening than mainstream providers, they can play a major role in prevention and health maintenance, with mainstream providers reserved for crisis care.

- **Educational level, literacy, and language preferences**--Assessment of the general educational level, literacy, and language preferences of the community should enable community co-change agents to develop suitably worded messages. Levels of literacy should be assessed for both the preferred language of the community, if it exists, and for English.

  For certain Asian/Pacific Islander groups, language may be a critical factor. Recent Indochinese immigrants, for example, may not speak any English at all. Hispanics, on the other hand, may simply prefer to have messages conveyed in their own language. Nevertheless, although dual-language messages have become popular in public campaigns directed at minority communities, such messages may be extremely offensive to some groups. The Japanese, for example, generally take great pride in their cultural assimilation, particularly their rapid mastery of English, and dual-language messages are generally insulting to Japanese-American communities.

As noted, the larger Federal, state and local communities may be able to supply some epidemiological data on health problems and health risks, but rarely with the specificity required for developing diffusion strategies. Moreover, centralized information on health beliefs and practices or on educational levels, literacy, and language preferences is simply not available from sources outside the community. Accordingly, the most important role for the larger community is the funding of ethnic-group and community-specific epidemiological studies, risk-factor surveys, and other relevant community profiles.

(3) Plan Diffusion Activities

Planning diffusion activities involves two major tasks--identifying appropriate communication channels and designing appropriate diffusion activities.

The most obvious communication channels preferred by minority audiences are the mass media--television channels, radio stations, national and community newspapers and magazines, and newsletters from various community-based organizations. But these may not be the most effective means of communicating health messages. Alcalay (1980) and Warnecke et al. (1975) believe that interpersonal communication, particularly from health experts or immediate family members, is more effective. Any number of community organizations can provide networks for direct communication--political and religious groups, social service agencies, community centers, etc. Thus, community co-change agents should survey all communication possibilities and identify the most credible and appropriate channels for community diffusion activities.

Exhibit 4 lists the common communication channels for the four minority groups addressed by the CDM. Again, these are likely communication channels; the most effective channels vary from community to community and must be determined through careful analysis.

In identifying communication channels, program planners will identify potential targets for diffusion activities.

- Activities for American Indian groups will focus on their numerous women's clubs, frequent community sporting events, the close relationship between grandparents and grandchildren, and the community's high regard for contemporary education.

- Activities for Asians/Pacific Islanders will focus on the importance of the church in their communities, the popularity of women's groups and businessmen's groups, Asian newspapers, ethnic grocery stores, and other ethnic shops.

- Activities for blacks will focus on the popularity of family reunions, the potential role of women's clubs and religious organizations, the importance of the workplace, and the power of peer groups.

- Activities for Hispanics will take into account that Hispanic men cannot be reached through the same channels as Hispanic women.

Since the most effective diffusion activities are linked to local communication channels and the characteristics of the target group, the larger community can be most helpful as a clearinghouse for tested activities and programs and as a switchboard linking co-change agents from similar communities who might benefit from direct exchanges of information. Exhibit 5 lists the diffusion activities suggested for each target population, indicating the locus or forum for these activities and the channels through which they can be promoted.

(4) Develop Diffusion Tools

Diffusion messages fall into two major categories: (1) educational messages that encourage and support behavior change or alert the receiver to particular health problems and (2) promotional messages that provide information on specific community events and health screening opportunities. Certain basic guidelines apply to the design of diffusion messages in each category.

- **Guidelines for producing educational messages**--All educational information materials should be developed using input from members of the target audience, especially when they are developed by the larger community.

  a. Public service announcements must be in the preferred language of the target population. Local vernacular may be appealing, but messages should be grammatically correct and slang used sparingly and carefully.

  b. Videos should feature actors from the same ethnic group as the target audience. They should wear ethnically appropriate clothing and hair styles, but should appear slightly more prosperous than most members of the target audience. The setting should also be familiar (i.e., mesa for Southwest Indians, cities for Puerto Ricans).

  c. Posters should be designed using the same guidelines that apply to videos. Sports personalities, movie stars, and TV actors are usually effective figures for such posters, especially if they are representatives of the target group.

  d. Pamphlets should be richly illustrated and geared to the appropriate reading level. Pretesting for readability and appeal is necessary. Some guides to pamphlet design are available, notably Readability Testing in Cancer Communications, a booklet published by the National Cancer Institute.

- **Guidelines for producing promotional messages**--These messages are usually produced at the community level, and co-change agents may need assistance in designing such materials. The guidelines for

producing educational messages are also applicable here, but there are a number of "how-to" manuals suitable for use by mainstream organizers and community co-change agents. These manuals may explain how to produce a public service announcement and how to get it aired, how to publish a brochure, where to get community funding and other procedures. The Media Handbook published by the American Hospital Association may also be useful.

MINORITY COMMUNICATION THEMES

The above guidelines for producing diffusion materials will be helpful to all change agents, regardless of the target population. However, the CDM also identifies certain themes that are effective in approaching minorities.

- American Indians are less likely to respond to "fear" messages than are other groups, perhaps because they are accustomed to living with fear. "Love of family," "maintaining independence," or "remaining strong" are the most persuasive themes for this group.

- Hispanic groups are more likely to respond to "fear" messages, especially those emphasizing the immediacy of possible death or disability (as long as these messages are within reason and offer solutions) and expressing concern for remaining children. "Love of family" is also a good theme for this group.

- "Love of family" is also thematically appropriate for Asian/Pacific Islander groups, as is "fear of dependency" (if carefully done). Themes for this group must somehow overcome attitudes of self-sufficiency, belief in self-control as a remedy, and fatalism--all of which limit the impetus for behavioral change.

- In black communities, the theme "do it for your loved ones" has been especially effective. If they are not overdone, "fear" messages (e.g., high blood pressure is a silent killer) may be persuasive, as long as remedies are suggested. Logical approaches, such as "You take care of your shoes, you take care of your car, so take care of yourself," may work as well.

Special attention to themes should be complemented by diffusion strategies geared to each minority. For example, articles aimed at American Indians or blacks should be placed in the sports section of local newspapers, while those aimed at Asians/Pacific Islanders or Hispanics are best placed in ethnic newspapers. Educational and promotional materials like posters and pamphlets should be distributed in places frequented by the target group. Materials for Asians/Pacific Islanders should be available at churches, refugee centers, local businesses, specialty food stores, restaurants, community centers, and immigration offices. Materials for American Indians, on the other hand, should be available at powwows, Indian Health Service clinics, urban centers, recreational centers, and trade stores. Materials for blacks should also be available at recreational centers, as well as churches, shopping centers, gas stations, and emergency rooms. And materials for Hispanics should be available at specialty food stores, restaurants, dance places, cinemas, churches, recreational centers, community service centers, and emergency rooms.

All of the foregoing suggestions for the approach and design of information programs are valuable in planning a community-based program. But the bottom line, again, is the community itself. The community is the final resource for diffusion activities, and programs that fail to integrate the advice of community leaders or consider specific ethnic characteristics have a diminished potential for success.

EXHIBIT 1

COMMUNITY-BASED DIFFUSION MODEL

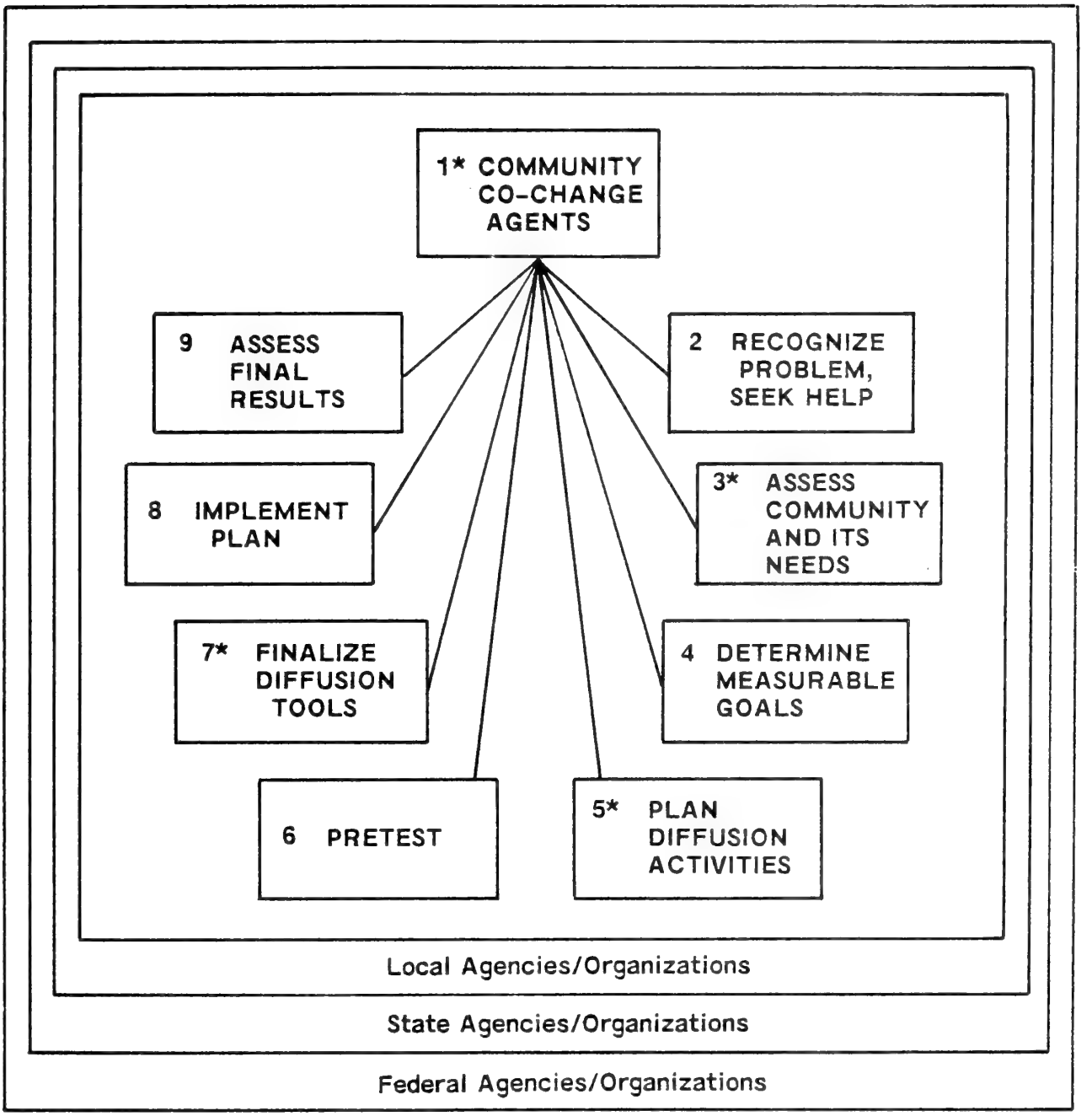

EXHIBIT 2

EXAMPLES OF COMMUNITY CO-CHANGE AGENTS (CCAs)

COMMUNITY CCAs	AMERICAN INDIAN	ASIAN PACIFIC	BLACK	HISPANIC
School teachers	X	X		X
Alcoholism counselors	X	X		
Religious leaders		X	X	X
Nurses	X		X	X
Club presidents	X	X	X	
Hometown clubs				X
Postmen			X	
Unlicensed health professionals		X		
Business proprietors		X		X
Sports personalities	X	X	X	X
Media personalities		X	X	X
Block captains			X	
Newspaper editors	X	X	X	X
WIC ladies		X	X	X
Community health clinics	X	X	X	X
Local chapter minority-oriented clubs and professional organizations	X	X	X	X
Local heart associations, cancer associations, and other health-related volunteer organizations	X	X	X	X
Businessmen's clubs	X	X	X	X

EXHIBIT 3

CHARACTERISTICS THAT CAN AFFECT DIFFUSION OF HEALTH INFORMATION

PREVALENCE/INCIDENCE OF PREVENTABLE AND TREATABLE ILLNESSES

High blood pressure
High blood cholesterol
Heart disease
Other

PREVALENCE/INCIDENCE OF RISK BEHAVIORS

Smoking
High sodium intake
Other dietary factors
Lack of exercise
Noncompliance with medical regimen
Other

HEALTH BELIEFS AND HEALTH PRACTICES

Concepts of disease
-- Fatalism/God's will
-- Naturalism
-- Life balance
-- Supernatural origin of disease
-- Superstition
Belief in susceptibility to disease
Belief in effectiveness of intervention
Crisis-reactive health care behavior
Preventive health care behavior
Use of non-Western medicine
Knowledge/Use of Mainstream health care services
Use of non-Western medical resources
-- Folk medicine/remedies
-- Herbalists
-- Curanderos
-- Medicine men
-- Food remedies
-- Charms and fetishes
-- Acupuncture

CULTURALLY RELATED TRAITS

Skepticism
Apathy
Fear/anxiety
Modesty
Stress
Machismo/invulnerability
Self-determination
Self-esteem
Other

LOCAL CUSTOMS AND BELIEFS

Religious beliefs
Tribal customs
Musical preferences
Language preferences
Other

DEMOGRAPHIC CHARACTERISTICS OF COMMUNITY

Sex distribution
Age distribution
Ethnic distribution
Urban
Rural
Suburban

SOCIOECONOMIC CONDITIONS/ CHARACTERISTICS

Family structure/influence
Literacy
Educational level
Employment conditions
-- Percent employed
-- Percent unemployed
-- Percent multiemployed
-- Percent underemployed
-- Occupational categories

COMMUNITY RESOURCES

Preventive health services
-- Availability
-- Access
-- Cost
-- Ethnicity of providers
Primary health care
-- Availability
-- Access
-- Cost
-- Ethnicity of providers
Transportation systems
Communication channels
Mass media
Interpersonal (formal)
Interpersonal (informal)

EXHIBIT 4

EXAMPLES OF COMMUNICATION CHANNELS

COMMUNITY COMMUNICATION CHANNELS	AMERICAN INDIAN	ASIAN PACIFIC	BLACK	HISPANIC
Family, general	X	X	X	X
Children	X	X	X	X
Hairdressers/barbers			X	
Sheriff/police departments			X	
Church leaders	X	X	X	X
"Public" nurses	X	X	X	X
Social workers	X	X	X	X
Cinema owners/ operators				X
Store proprietors		X		X
Professional organizations	X	X	X	X
Senior centers	X	X	X	
Work crew leaders			X	X
"Ethnic" newspapers	X	X		X
Political leaders	X	X	X	
Women's church groups	X	X	X	X
Television/radio	X	X	X	X
Mainstream health workers	X	X	X	X
Friends/peers	X	X	X	
Social/cultural clubs	X	X	X	X

EXHIBIT 5(1)

DIFFUSION ACTIVITIES, LOCATIONS, AND CHANNELS

ACTIVITY/MATERIAL	LOCATION/FORUM FOR ACTIVITY	CHANNELS FOR PROMOTING ACTIVITY
AMERICAN INDIAN COMMUNITIES		
Health booths distributing information on health problems, risk behaviors, etc.	Rodeos, "runs," and other community sporting events	Tribal newspapers, radio stations, alcoholism counselors and nurses
Healthful recipes, with discussions of superior diets and fitness of ancestors		Tribal newspapers, radio stations, alcoholism counselors and nurses
Instructional units on high blood pressure, heart disease, and associated risk factors, with training provided in measuring blood pressure (this activity builds on the close relationship between young people and elders and the high regard for education among elders)	Junior high and senior high classrooms	Educational media--newsletters, etc.
ASIAN/PACIFIC ISLANDER COMMUNITIES		
Health fairs	Churches	Ethnic newspapers, community bulletin boards
Guest speakers	Businessmen's groups	Ethnic newspapers, club media
Fundraising activities	Businessmen's groups	Ethnic newpapers, club media
Recruitment of change agents	Businessmen's groups	Ethnic newspapers, club media
Introduction of new food products (low-sodium soy sauce) and distribution of healthful recipes	Ethnic grocery stores	Ethnic newspapers

EXHIBIT 5(2)

ACTIVITY/MATERIAL	LOCATION/FORUM FOR ACTIVITY	CHANNELS FOR PROMOTING ACTIVITY
Distribution of health information	Mobile vans, health agencies/centers, recently immigrated health professionals	
BLACK COMMUNITIES		
Genealogy kit with instructions for identifying relatives with high blood pressure and heart disease and information on nutrition, smoking cessation, exercise, medical treatment, and other disease prevention/ health promotion topics	Family reunions	Mass media, women's club members, Sunday school teachers
High blood pressure screening and followup; monitoring distribution of related health information	Workplace	Union stewards, union bulletin boards
	Churches	Lay workers, Ministers, Deacons, Ushers, Church nurses, Influential church members
"Rap" contests producing winning raps on cardiovascular risks and recommended behaviors	Local festivals and concerts	Local TV and radio stations
Speeches by individuals under treatment for high blood pressure or high blood cholesterol who emphasize their personal satisfaction at having identified a serious health problem and doing something about it.	Small group meetings	Media, civic leaders

EXHIBIT 5(2)

ACTIVITY/MATERIAL	LOCATION/FORUM FOR ACTIVITY	CHANNELS FOR PROMOTING ACTIVITY
HISPANIC COMMUNITIES		
Health fairs, organized and conducted by staff from local churches (would be attended primarily by women and children)	Churches	Priests, church program coordinators, church bulletin boards, local newspapers
Speakers and written forms of health information	Hometown clubs (meetings and annual picnics)	Club media, community media
Recruitment of co-change agents, fundraising, speakers, and distribution of materials	Professional men's clubs	Club media Community media
Blood pressure screening and followup, with provision of health information	Workplaces--canneries, factories, vegetable and fruit fields, etc.	Union media, management media, community media
Discussions of high blood pressure and high blood cholesterol with distribution of messages about diet, recipes, food preparation, etc.	Small group meetings in people's homes	Community media, civic leaders, Spanish newspapers, Spanish radio stations

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GLOSSARY

Listed below are definitions of selected terms used in diffusion and communication theories. These definitions are adapted from the work of Rogers and Shoemaker (1974).

Change Agent--A professional who influences innovation-decisions in a direction deemed desirable by a change agency. This is an official position in the sense that influencing such decisions is part of the agent's job. A change agent need not be an individual from outside the social system targeted for diffusion but may serve that role within his or her own social system. In the context of this report, professional health educators and public health administrators or health providers are prime examples of change agents.

Co-Change Agent--An opinion leader who has become actively involved in diffusion efforts. The co-change agent may have been recruited by a change agent or may function in the absence of an offical change agent, as when community groups organize to meet a perceived community need. While such individuals are actively involved in diffusion, they are not professional change agents and can exist inside or outside a social system targeted for diffusion. The term co-change agent was developed by the National Heart, Lung, and Blood Institute (NHLBI) in the development of the community-based diffusion model (CDM) to better identify and highlight the key role of community leaders.

Communication Channels--The way a message gets from a source to a receiver. Mass media channels are most effective in creating an awareness of a new idea, while interpersonal channels are most effective in persuading people to adopt a new idea. In stimulating a new health behavior, the public service announcement is often used by mass media to create awareness of the behavior. Health professionals are frequently used as interpersonal channels to diffuse health information, as are social support systems like families, neighbors, and friends.

Diffusion--How innovation is communicated through certain channels over time among members of a social system.

Innovation--An idea or behavior perceived as new. Although in the health area there are some technological innovations (e.g., new drug to treat cancer), most innovations considered in this report are health actions. Perhaps some are known to the individual but are not currently being practiced (e.g., exercise).

Opinion Leaders--Individuals who can informally influence other people's attitudes and behaviors. Opinion leadership is an informal status not necessarily related to an individual's formal position in the social system but earned and maintained by technical competence, personal characteristics such as charisma or social accessibility, and conformity to the system's norms. Opinion leaders are almost always members of the social systems in which they exert influence.

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*U.S. G.P.O. 1987-181-296:61111

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September 1987